

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$462.00 for date of service 07/06/01.
- b. The request was received on 03/01/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Undated Letter
 - b. HCFA-1500
 - c. TWCC 62
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and Letter responding to the Request for Dispute dated 03/11/01
 - b. TWCC 62
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The Commission case file did not contain a Notice of Medical Request Resolution sign sheet. The carrier's initial response dated 03/05/02 is included in the file. The Commission requested 14 day additional information from the provider on 04/12/02. The provider did not respond to the 14 day request for additional information. The carrier's 14 day response was received by the Commission on 04/19/02, therefore, the carrier's response is considered timely.
4. The Commission's request for additional 14 day additional information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Undated Letter:

"76499-27-22...is documented in the operative report....A C-arm is a piece of radiology equipment referred as X-ray....Our facility is asking for reimbursement for the additional supplies and materials used during the procedure....According to payment of \$88 carrier is reimbursing us according to another codes value...this is not fair and reasonable. Our facility has supplied DOP that shows complexity and value of our service."

2. Respondent: Letter dated 03/11/02:
“**CPT 76499-27-22**...Fluoroscopy...The provider is not using the code listed within the Texas Fee Schedule....The...Fee Schedule...recognizes CPT code 76000 as Fluoroscopy (separate procedure)....The use of Modifier 22 is not supported by the documentation submitted....***the only reimbursement allowed for facility charges shall be the following:***...Sterile Trays...Anesthesia supplies...Postoperative Monitoring....(Carrier) does not feel the provider is due any further reimbursement.”

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service eligible for review is 07/06/01.
2. The medical dispute packet does not contain any medical documentation in accordance with Rule 133.1 (a) (3) (D), therefore, no reimbursement is recommended.

The above Findings and Decision are hereby issued this 31st day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.